

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

Request for Temporary Coverage of Dual Eligible

Patient Information (Please provide as much identifying information as possible)

Name: _____
Medicaid Recipient ID #: _____
Social Security Number: _____
Medicare (HIC) Number: _____
PDP Name and ID number: _____
Date of Birth: _____

Pharmacy Name: _____
Pharmacist to contact: _____
Pharmacy phone number (required): _____

Description of Problem:

Unable to identify PDP enrolled in ☐
Able to identify PDP but not Patient ID for Plan ☐
PDP name _____
Able to bill PDP but co-pays returned by PDP too high for dual ☐

Was E-1 (eligibility verification; find) transaction sent to TrOOP facilitator (NDC Health):

___ YES ___ NO

If yes, what information was returned: _____

Was claim sent to Wellpoint for contingency processing: ___ YES ___ NO

If yes, what message was returned: _____

HFS Use Only

HFS Action Taken: _____

Provider Signature _____ **Date** _____

Fax: 217/782-5672 or 217/558-1531 or 217/524-7535